MISSOURI MEDICAID CASE MIX:
RUG-IV 48 GROUP MODEL AND VALUE BASED PURCHASING

2022 LONG-TERM CARE PROVIDER MEETING

Stacey Bryan, RN, BSN, RAC-CT
State RAI Coordinator
Section for Long-Term Care Regulation
Missouri Department of Health and Senior Services
www.health.mo.gov

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

MISSOURI MEDICAID PAYMENT CHANGES

On 6-30-22 the Missouri Department of Social Services (DSS) MO HealthNet Division (MHD) posted Proposed Rule 13 CSR 70-10.020 which outlines the new Medicaid reimbursement methodology for NHs effective for dates of service **beginning July 1, 2022**.

The primary changes include:

- Updating the cost base for the rates (i.e., rebasing);
- Applying an acuity adjustment or **Case Mix Index (CMI) to patient care costs**;
- Providing quality based incentives or **Value Based Purchasing (VBP) add-ons** to the rate when the facility meets specified quality measure criteria.

❖ **These reimbursement changes are contingent upon approval by CMS.**

HOLD HARMLESS

A provision of the state fiscal year (SFY) 2023 rate methodology is that no rate shall be less than the rate in effect for June 30, 2022. For each facility, the rates calculated for FY 2023 will be compared to that facility's rate in effect as of June 30, 2022. The facility will receive the greater of those two rates.

CASE MIX REIMBURSEMENT

- Reimbursement levels differ based on the resource needs of the residents as measured by items on the MDS.
- Residents with heavy care needs require more staff resources and payment levels should be higher than for residents with less intensive care needs.
- Case Mix Index (CMI) is a weight or numeric score assigned to a resident classification system grouping that reflects the relative resources predicted to care for a resident.
- The average acuity level of patients in a facility can be determined and expressed by calculating an average of the individual CMI values for each resident.

MISSOURI CASE MIX REIMBURSEMENT

- Over half of the State Medicaid programs use the MDS for their case mix payment systems.
- States have the option of selecting the system that better suits their Medicaid long-term care population.
- The (Resource Utilization Group) RUG IV, 48 groups, Logic Version 1.03, CMI Set F01 (48-Grp) (i.e., RUG IV 48 group model classification system) is listed in the proposed rule to be used to determine the CMI for Missouri homes.
- The CMI will go into the patient care component of a facility's Medicaid rate.

SEMI-ANNUAL CASE MIX ADJUSTMENTS

Each facility's patient care per diem rate will be adjusted semi-annually using a current Medicaid CMI. The Medicaid CMI will be updated based on the facility's average Medicaid CMI using the RUGS IV 48 group model classifications from the two (2) preceding quarterly calculations. The applicable Medicaid CMI are as follows:

- Effective for dates of service beginning January 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding July 1 and October 1 quarterly Medicaid CMI calculations.
- Effective for dates of service beginning July 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid CMI calculations.

(Proposed Rule 13 CSR 70-10.020)

RUG-IV 48-GROUP MODEL

Extensive Services

ES3, ES2, ES1

Rehabilitation

RAE, RAD, RAC, RAB, RAA

Special Care High

HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1

Special Care Low

LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1

Clinically Complex

CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1

Behavior Symptoms & Cognitive Performance

BB2, BB1, BA2, BA1

Reduced Physical Function

PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA2

CALCULATION OF THE ADL SCORE

- The ADL score is a component of the calculation for placement in all RUG-IV groups.
- The ADL score is based upon the four "late loss" ADLs (bed mobility, transfer, toilet use, and eating), and this score indicates the level of functional assistance or support required by the resident. Research indicates that the late loss ADLs predict resource use most accurately.
- The RUG-IV total ADL Score ranges from 0 through 16, with 0 being the most independent and 16 being the most dependent.
- All episodes of the ADL that occurred during the 7-day look-back should be taken into account to determine how the MDS is coded because a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts.

EVALUATION FOR DEPRESSION

- Signs and symptoms of depression are used as a third-level split for the Special Care High category, Special Care Low category, and Clinically Complex category.
- Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, Section D. Refer to Appendix E for cases in which the PHQ-9© (or PHQ-9-OV©) is complete but all questions are not answered.
- The resident qualifies as depressed for RUG-IV classification in either of the two following cases:
  - The D0300 Total Severity Score is greater than or equal to 10 but not 99,

    or
  - The D0600 Total Severity Score is greater than or equal to 10.

SECTION I - ACTIVE DIAGNOSES

The diagnoses coded in Section I must:

- Have a physician (or physician extender) documented diagnosis in the last 60 days;
- Be active in the last 7-day look-back period. Active diagnoses have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Check off each active disease. Check all that apply. If a disease or condition is not specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.

- Item I2300 UTI, (which does not affect the RUG-IV 48 Groups but does impact the UTI QM) has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-12 for specific coding instructions for Item I2300 UTI.

O0100: SPECIAL TREATMENTS & PROCEDURES

Review medical record to determine whether the resident received or performed any of the treatments, procedures, or programs within the last 14 days.

Coding Instructions for Column 2: Check all treatments, procedures, and programs received or performed by the resident after admission/entry or reentry to the facility and within the 14-day look-back period.

Coding Tips:

- Facilities may code treatments, programs and procedures the resident performed themselves independently or after set-up by facility staff.
- Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators.

RESTORATIVE NURSING SERVICES

Restorative nursing can affect the Rehabilitation, Behavior Symptom & Cognitive Performance, and Reduced Physical Function RUG-IV groups.

- H0200C Urinary toileting program and/or H0500 Bowel toileting program (count as one service even if both provided)
- O0500A Passive ROM and/or O0500B Active ROM (count as one service even if both provided)
- O0500C Splint or brace assistance
- O0500D Bed mobility and/or O0500F Walking training (count as one service even if both provided)
- O0500E Transfer Training
- O0500G Dressing and/or grooming training
- O0500H Eating and/or swallowing training
- O0500I Amputation/prostheses care
- O0500J Communication training

RESTORATIVE NURSING SERVICES

To code a toileting program or trial on the MDS in items H0200C Urinary toileting program and/or H0500 Bowel toileting program the following documentation must be in the medical record:

- Implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern;
- Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and
- Notations of the resident's response to the toileting program and subsequent evaluations, as needed.

A toileting program does not refer to simply tracking continence status, changing pads or wet garments, or random assistance with toileting or hygiene.

RESTORATIVE NURSING SERVICES

The following criteria for restorative nursing programs must be met in order to code O0500:

- Measurable objective and interventions must be documented in the care plan and in the medical record.
- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- A RN or LPN/LVN must supervise the activities in a restorative nursing program. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

RESTORATIVE NURSING SERVICES

MO State Regulation: 19 CSR 30-85.042

(23) Facilities shall conduct at least annual in-service education for nursing personnel including training in restorative nursing. This training by a registered nurse or qualified therapist shall include: turning and positioning for the bedridden resident, range of motion (ROM) exercises, ambulation assistance, transfer procedures, bowel and bladder retraining and self-care activities of daily living.

Restorative Nurse Assistant DHSS webpage:

https://health.mo.gov/safety/cnaregistry/rna.php

Extensive Services

Treatments or Services	ADL Score	RUG	CMI
Tracheostomy care while a resident (O0100E2) **and** Invasive mechanical ventilator while a resident (O0100F2)	2 - 16	ES3	3.00
Tracheostomy care while a resident (O0100E2) **or** Invasive mechanical ventilator while a resident (O0100F2)	2 - 16	ES2	2.23
Infection isolation while a resident (O0100M2)	2 - 16	ES1	2.22

INFECTION ISOLATION

O0100M2 Isolation or quarantine for active infectious disease while a resident: Should only be coded when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

- Examples of when the isolation criteria would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Rehabilitation

Treatments or Services	ADL Score	RUG	CMI
• 150 or more total therapy minutes (SLP in O0400A1,2,3; OT in O0400B1,2,3; PT in O0400C1,2,3) **and** at least 5 distinct calendar days of any combination of the 3 disciplines (as documented in O0420) • 45 or more total therapy minutes (SLP in O0400A1,2,3; OT in O0400B1,2,3; PT in O0400C1,2,3) **and** at least 3 distinct calendar days of any combination of the 3 disciplines (as documented in O0420) **and** 2 or more restorative nursing services for 15 or more min/day for 6 or more of the last 7 days	15 - 16	RAE	1.65
	11 - 14	RAD	1.58
	6 -10	RAC	1.36
	2 - 5	RAB	1.10
	0 - 1	RAA	0.82

Special Care High

Conditions or Services

- Comatose (B0100) **and** completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0110I1 all equal 4 or 8)
- Septicemia (I2100)
- Diabetes (I2900) **and** insulin injections (N0350A) for all 7 days **and** insulin order changes (N0350B) on 2 or more days
- Quadriplegia (I5100) with ADL score ≥ 5
- COPD (I6200) **and** SOB when lying flat (J1100C)
- Fever (J1550A) **and** one of the following:
  - ~ Pneumonia (I2000)
  - ~ Vomiting (J1550B)
  - ~ Weight loss (K0300 = 1 or 2)
  - ~ Feeding tube while or while not a resident (K0510B1 or K0510B2) **and**
    - o K0710A3 is 51% or more of total calories **or**
    - o K0710A3 is 26% to 50% of total calories **and** K0710B3 is 501 cc/day or more
- Parenteral/IV feedings while or while not a resident (K0510A2 or K0510A1)
- Respiratory therapy for all 7 days (O0400D2)

Special Care High

ADL Score	Depressed	RUG	CMI
15-16	Yes	HE2	1.88
15-16	No	HE1	1.47
11-14	Yes	HD2	1.69
11-14	No	HD1	1.33
6-10	Yes	HC2	1.57
6-10	No	HC1	1.23
2-5	Yes	HB2	1.55
2-5	No	HB1	1.22

RESPIRATORY THERAPY

O0400D2 Respiratory Therapy Days: Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day.

Respiratory therapy: Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

RESPIRATORY THERAPY

For purposes of the MDS, providers should record services for **respiratory therapy** when the following criteria are met:

- The physician orders the therapy;
- The physician's order includes a statement of frequency, duration, and scope of treatment;
- The services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
- The services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
- The services must be reasonable and necessary for treatment of the resident's condition.

RESPIRATORY THERAPY

Appendix A definition of Respiratory therapy: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

Special Care Low

Conditions or Services

- Cerebral palsy (I4400) with ADL score ≥ 5
- Multiple sclerosis (I5200) with ADL score ≥ 5
- Parkinson's disease (I5300) with ADL score ≥ 5
- Respiratory failure (I6300) **and** oxygen therapy while a resident (O0100C2)
- Feeding tube while or while not a resident (K0510B1 or K0510B2) **and**
  - K0710A3 is 51% or more of total calories **or**
  - K0710A3 is 26% to 50% of total calories **and** K0710B3 is 501 cc/day or more
- 2 or more stage 2 PUs (M0300B1) with 2 or more selected skin treatments*
- Any stage 3 PU (M0300C1), stage 4 PU (M0300D1), or unstageable PU (d/t slough and/or eschar) (M0300F1) with 2 or more selected skin treatments*
- 2 or more venous/arterial ulcers (M1030) with 2 or more selected skin treatments*
- 1 stage 2 PU (M0300B1) and 1 venous/arterial ulcer (M1030) with 2 or more selected skin treatments*
- Foot infection (M1040A), diabetic foot ulcer (M1040B) or other open lesion of foot (M1040C) with application of dressings to feet (M1200I)
- Radiation treatment while a resident (O0100B2)
- Dialysis treatment while a resident (O0100J2)

Special Care Low

*Skin Treatments	ADL Score	Depressed	RUG	CMI
•Pressure relieving chair (M1200A) and/or bed (M1200B) (count as 1 treatment even if both provided) •Turning & repositioning (M1200C) •Nutrition or hydration intervention (M1200D) •PU care (M1200E) •Application of dressings not to feet (M1200G) •Application of ointments not to feet (M1200H)	15-16	Yes	LE2	1.61
	15-16	No	LE1	1.26
	11-14	Yes	LD2	1.54
	11-14	No	LD1	1.21
	6-10	Yes	LC2	1.30
	6-10	No	LC1	1.02
	2-5	Yes	LB2	1.21
	2-5	No	LB1	0.95

Clinically Complex

Conditions or Services	*Skin Treatments
• Pneumonia (I2000) • Hemiplegia/hemiparesis (I4900) with ADL score ≥ 5 • Surgical wounds (M1040D) or open lesions (M1040E) with any selected skin treatment* • Burns (M1040F) • Chemotherapy while a resident (O0100A2) • Oxygen therapy while a resident (O0100C2) • IV medications while a resident (O0100H2) • Transfusions while a resident (O0100I2)	• Surgical Wound Care (M1200F) • Application of dressing (not to feet) (M1200G) • Application of ointments (not to feet) (M1200H)

Clinically Complex

ADL Score	Depressed	RUG	CMI
15–16	Yes	CE2	1.39
15-16	No	CE1	1.25
11-14	Yes	CD2	1.29
11-14	No	CD1	1.15
6-10	Yes	CC2	1.08
6-10	No	CC1	0.96
2-5	Yes	CB2	0.95
2-5	No	CB1	0.85
0-1	Yes	CA2	0.73
0-1	No	CA1	0.65

Behavior Symptoms & Cognitive Performance

Cognition and Behaviors

- BIMS score (C0500) ≤ 9
- Comatose (B0100) **and** completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0110I1 all equal 4 or 8)
- Severely impaired cognitive skills (C1000 = 3)
- 2 or more of the following impairment indicators are present:
  - Problem being understood (B0700 > 0)
  - Short-term memory problem (C0700 = 1)
  - Cognitive skills problem (C1000 > 0)

  and

  1 or more of the following are present:
  - Severe problem being understood (B0700 ≥ 2)
  - Severe cognitive skills problem (C1000 ≥ 2)
- Hallucinations (E0100A)
- Delusions (E0100B)
- Physical behaviors directed toward others (E0200A = 2 or 3)
- Verbal behavioral symptoms directed toward others (E0200B = 2 or 3)
- Other behavioral symptoms not directed toward others (E0200C = 2 or 3)
- Rejection of care (E0800 = 2 or 3)
- Wandering (E0900 = 2 or 3)

Behavior Symptoms & Cognitive Performance

ADL Score	Restorative 2 or more services for 15 or more minutes/day for 6 or more of the last 7 days	RUG	CMI
2-5	Yes	BB2	0.81
2-5	No	BB1	0.75
0-1	Yes	BA2	0.58
0-1	No	BA1	0.53

Reduced Physical Function

	ADL Score	Restorative 2 or more services for 15 or more minutes/day for 6 or more of the last 7 days	RUG	CMI
Residents who do not meet the conditions of any previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have an ADL score greater than 5, are placed in this category.	15-16	Yes	PE2	1.25
	15-16	No	PE1	1.17
	11-14	Yes	PD2	1.15
	11-14	No	PD1	1.06
	6-10	Yes	PC2	0.91
	6-10	No	PC1	0.85
	2-5	Yes	PB2	0.70
	2-5	No	PB1	0.65
	0-1	Yes	PA2	0.49
	0-1	No	PA1	0.45

VBP INCENTIVE

Value Based Purchasing (VBP) Incentive. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. The facility shall receive a per diem adjustment for each Quality Measure (QM) Performance threshold that it meets, up to a maximum per diem adjustment of seven dollars ($7.00). The threshold for each QM is based on national cut-points used by CMS in its Five Star Rating System. Each threshold is the minimum value needed in order to earn the maximum points for that QM. These thresholds are listed in Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017. The QM Performance Measure threshold and per diem adjustments are as follows:

Value Base Payment Incentives

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	10.0%	$1.00
Decline in Mobility on Unit	8.0%	$1.00
High-Risk Residents w/ Pressure Ulcers	2.7%	$1.00
Anti-psychotic Medications	6.8%	$1.00
Falls w/ Major Injury	1.3%	$1.00
In-dwelling Catheter	1.1%	$1.00
Urinary Tract Infection	1.9%	$1.00

(Proposed Rule 13 CSR 70-10.020)

VBP INCENTIVE

B. A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for a VBP Incentive. The VBP percentage will be determined by the total QM score calculated from the Five-Star Rating System scores for each of the long-stay QMs. The VBP percentage for each scoring range is listed in the following table:

VBP Percentages

QM Scoring Tier	Minimum Score	VBP Percentage
1	600	100%
2	520	75%
3	440	50%
4	360	25%
5	0	0%0

(Proposed Rule 13 CSR 70-10.020)

SEMI-ANNUAL VBP INCENTIVE ADJUSTMENTS

Semi-Annual Adjustment for VBP Incentive. Each facility's QM Performance data shall be reevaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The VBP will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The QM Performance data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. A facility must meet the criteria set forth in (11)(F)3. each period and will lose any per diem adjustments for which it does not continue to qualify.

(Proposed Rule 13 CSR 70-10.020)

MENTAL ILLNESS ADD-ON

Mental Illness Diagnosis Add-On. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. If at least forty percent (40%) of a facility's Medicaid participants have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00):

(I) Schizophrenia

(II) Bi-polar

Semi-Annual Adjustment for Mental Illness Diagnosis Add-On. Each facility's Mental Illness Diagnosis data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The Mental Illness Diagnosis will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The Mental Illness Diagnosis data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment.

(Proposed Rule 13 CSR 70-10.020)

RAI MANUAL ERRATA

MDS3.0RAIManualv1.17R.Errata.v2.July.15.2022, available in the Downloads section of the MDS 3.0 RAI Manual webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

This file contains revisions to pages in Chapter 3, Section I, of the MDS 3.0 RAI Manual v1.17.1R that clarifies the need for a detailed evaluation and appropriate diagnostic information to support a diagnosis, such as for a mental disorder, prior to coding the diagnosis on the MDS, and the steps that may be necessary when a resident has potentially been misdiagnosed. An example of when a diagnosis should not be coded in Section I due to lack of a detailed evaluation and appropriate diagnostic information to support the diagnosis has also been added to this section. Changed manual pages are I-12 and I-16 and are marked with the footer "October 2019 (R)."

RAI MANUAL ERRATA

On page I-12, a bullet was added under Coding Tips clarifying what practitioners should do when they have potentially misdiagnosed residents. In situations where practitioners have potentially misdiagnosed residents with a condition for which there is a lack of appropriate diagnostic information in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded, and a referral by the facility and/or the survey team to the State Medical Boards or Boards of Nursing may be necessary.

On page I-16, the following supporting example was added.

4. The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.

Coding: Schizophrenia item (I6000), **would not be checked**.

Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.

SUMMARY

- Documentation in the medical record should support the coding of the MDS.
- The MDS process should be a team effort.
- Education with staff may be needed.
- Follow RAI Manual instructions for item coding and MDS time frames.
- An accurate MDS generates an accurate RUG and CMI.

STATE REFERENCES

- Public Notice of Medicaid Prospective Reimbursement Plan for Nursing Homes
  https://dss.mo.gov/mhd/files/public-notice-nursing-facility-reimbursement-plan-20220630.pdf
- Proposed Rule of Medicaid Prospective Reimbursement Plan for Nursing Homes
  https://dss.mo.gov/mhd/files/13c70-10-020-proposed-rule-draft-20220630.pdf
- MO HealthNet Division Nursing Home Reimbursement Resources
  https://dss.mo.gov/mhd/providers/nursing-home-reimbursement-resources.htm

CMS REFERENCES

- MDS 3.0 RAI Manual v1.16
  https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf
- MDS 3.0 RAI Manual v1.17.1
  https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf
- The RUG IV, 48 groups, Logic Version 1.03, CMI Set F01 (48-Grp) (i.e., RUG IV 48 group model classification system)
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation
  - Applicable files are:
    - RUG-IV DLL Package V1.04.1 Final.zip
    - RUG III Files & RUG IV Files.zip

Subscribe to Section for Long-Term Care Regulation's weekly free listserv

https://cntysvr1.lphamo.org/subscribeltc.html

- Main form of communication from the State to providers.
- Includes changes/updates/educational opportunities.

THANK YOU

STACEY BRYAN
STATE RAI COORDINATOR
STACEY.BRYAN@HEALTH.MO.GOV
573-751-6308

DANETTE BEESON
STATE AUTOMATION COORDINATOR
DANETTE.BEESON@HEALTH.MO.GOV
573-522-8421